

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

0050990

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 318 Primary Registration District No. 1008 Registrar's No. 13141 STATE FILE NUMBER

FILED JAN 16 1964

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>St. Louis</u>		c. CITY OR TOWN <u>St. Louis</u>	
Length of stay in 1b <u>40 years</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) <u>City Hospital</u>		d. STREET ADDRESS (If outside, give location) <u>914 Biddle (rear)</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MERILEE DOLL</u>		4. DATE OF DEATH Month <u>12</u> Day <u>6</u> Year <u>63</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>UNK</u>
9. AGE (last birthday) <u>53</u>		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>UNK</u>	
11. BIRTHPLACE (City and state or country) <u>UNK</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>	
13a. FATHER'S NAME <u>UNK</u>		13b. MOTHER'S MAIDEN NAME <u>UNK</u>	
14. NAME OF HUSBAND OR WIFE <u>unknown</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>	
16. SOCIAL SECURITY NO. <u>UNK</u>		17. INFORMANT <u>Helen L. Taylor - 1300 Clark</u>	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CANCER OF Stomach</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last: DUE TO (b) <u>151X</u> DUE TO (c) <u>UNK</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy, in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour <u>12:30</u> a.m. <u>PM</u> Month, Day, Year	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION <u>Kirkwood Mo</u>	
20g. COUNTY		20h. STATE	
21. I attended the deceased from <u>12:30 P.M.</u> to <u>her</u> and last saw <u>him</u> alive on <u>1-6-64</u> Death occurred at <u>12:30 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Deed or title) <u>Helen L. Taylor, Curator</u>		22b. ADDRESS <u>1300 Clark</u>	
22c. DATE SIGNED <u>1-6-64</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	
23b. DATE <u>1-7-64</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Pathe Dixon</u>	
23d. LOCATION (City, town, or county) <u>Kirkwood Mo</u>		23e. STATE <u>Mo</u>	
24. FUNERAL DIRECTOR <u>A. H. Burkes</u>		25. DATE RECD. BY LOCAL REG. <u>JAN 7 1964</u>	
26. REGISTRAR'S SIGNATURE <u>Loan Smith, M.D.</u>		27. ADDRESS <u>3901 Ashland</u>	

DO NOT WRITE ON THIS STUB

AMENDED

VS 300  
Rev. 4/59

1

2

3

4

5

6

7

8

9

10

11

12

13

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed 710 Embalmer  
\_\_\_\_\_  
Licensed Embalmer No. \_\_\_\_\_  
P. O. Address and

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.